MDR: M4-02-2289-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 06/06/01 and 06/08/01.
   b. The request was received on 02/27/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFAs-1500
   c. TWCC 62 forms
   d. EOBs from other insurance carriers
   e. Medical documentation
   f. Additional Documentation received by the Division on 06/07/02
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and responses to the Request for Medical Dispute Resolution received by the Division on 03/12/02, 03/22/02, 03/25/02, 06/17/02, and 07/10/02
   b. HCFAs-1500
   c. TWCC 62 forms
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/27/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/02/02. The response from the insurance carrier was received in the Division on 07/10/02. Based on 133.307 (i) the insurance carrier's response is timely. The

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of disputed Services
"We feel that we are due full reimbursements for the durable medical equipment we provided this patient with. The Insurance [sic] Carrier [sic] is Stating [sic] we were over paid and recieved [sic] payments at a Fair [sic] and Reasonable [sic] rate. This is 'Incorrect [sic] & Untrue[sic]'. We have billed this equipment at a Fair [sic] & Reasonable [sic] rate. And have provided Proof [sic] by Sending [sic] ExampleS [sic] (illegible word) by other carriers for the same Service [sic]. We are requesting Additional [sic] Payments [sic] and Interest [sic] on the overdue claims."

2. Respondent: Letter dated 03/12/02
"The provider has billed HCPCS code E0236 & E1399 for water circulating pad. The definition in the **TWCC 1996 MFG**…for HCPCS code E0236…is '*Pump for water circulating pad.'* …HCPCS code E0237 is listed with the definition **'Water circulating heat/cold pad with pump'.** This is important to note because the provider is using 2 codes (E0236 & E1399) instead of using one code E0237 that is clearly the correct code and fits the definition of what the provider is billing for according to the documentation provided….It is (Audit Company's) position that the provider unbundled these charges so that they would not exceed the $500 parameter set by preauthorization rule 134.600….The reimbursement amounts made for all the HCPCS codes listed was based on the…Payment System….This methodology is widely used and accepted throughout the industry as a fair and reasonable method for calculating fees and reimbursement."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 06/06/01 and 06/08/01.

2. The carrier denied the billed charges by denial codes,
"A – PREAUTHORIZATION REQUIRED BUT NOT REQUESTED";
"G – UNBUNDLING";
"M – NO MAR SET BY TWCC-REDUCED TO FAIR AND REASONABLE";
"G – WATER CIRCULATING PAD IS GLOBAL TO THE WATER CIRCULATING UNIT";
"M – IT APPEARS THAT THIS BILL WAS OVERPAID, NOTHING MORE IS DUE AT THIS TIME, PERHAPS A RECOUPMENT MAY BE IN ORDER OSTEOGENESIS SHOULD OF BEEN ALLOWED AT $32000, ALSO FITTING AND TRAINING IS OUT OF SCOPE OF LICENSURE."
"D – DUPLICATE BILL Re-evaluation THE AUDIT WILL STAND AS INITIALLY EVALUATED APPEARS THAT CODE E0748 WAS OVERPAID ON THE FIRST BILLING/SUBMISSION. THERE WILL BE NO ADD. 'TL REIMBURSEMENT. —";

3. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $959.00; the amount paid is $72.66; the amount in dispute is $886.34.

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
06/06/01	E0236NU	$494.00	$0.00	M,A,D	DOP	MFG GI (VIII) (A); HCPCS descriptor	There is no "-NU" modifier in the MFG. Therefore, **no** reimbursement is recommended.
06/06/01	E1399	$155.00	$$0.00	M,A,G,D	DOP	Rule 133.307 (g) (3) (D), (E) Rule 133.600 (h) (11); 133.304 (i); HCPCS descriptor TWCC Importance of Proper Billing listed in the Table of Contents of the MFG; MFG (I) (B)	Per Rule 133.307 (g) (3) (D), the reimbursement data evidence submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" Out of the six EOBs submitted by the provider, one was not redacted and three had the address of the patient. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The insurance carrier submitted a methodology that meets Rule 133.304 (i). Although this CPT code does not need to be preauthorized, the HCPCS code E0327 would have better described the DME billed. E0237 lists "Water circulating heat/cold pad with pump". E1399 is global to the water circulating unit, E0236. **No** reimbursement is recommended.
06/08/01	L0960	$85.00	$12.66	M,D	DOP	Rule 133.307 (g) (3) (D), (E); Rule 133.3904 (i); HCPCS descriptor	Per Rule 133.307 (g) (3) (D), the reimbursement data evidence submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" Out of the six EOBs submitted by the provider, one was not redacted and three had the address of the patient. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The insurance carrier submitted a methodology that meets Rule 133.304 (i). **No** reimbursement is recommended.
06/08/01	E1399	$40.00	$0.00	M,G,D	DOP	Rule 133.307 (g) (3) (D), (E); 133.304 (i); HCPCS descriptor	Per Rule 133.307 (g) (3) (D), the reimbursement data evidence submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" Out of the six EOBs submitted by the provider, one was not redacted and three had the address of the patient. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The insurance carrier submitted a methodology that meets Rule 133.304 (i). **No** reimbursement is recommended.

06/08/01	97139TN	$185.00	$0.00	M,A,D	DOP	CPT descriptor; MFG (I) (C) (1) (q); Rule 133.307 (g) (3) (B), (D); 133.304 (i); TWCC Importance of Proper Billing listed in the Table of Contents of the MFG;	The descriptor for CPT code 97139 as "**DOP** unlisted therapeutic procedure, specify". The MFG states "when billing for the following services, identify each with the appropriate code and alpha modifier as indicated below:… q. 97139-TN TENS application for trial basis (includes supplies/training)". The provider lists "97139-TN" as "TRAINING/FITTING FEES BONE GROWTH STIMULATOR". According to TWCC proper coding of services is essential for proper reimbursement. The provider billed a CPT code with does not describe the procedure billed on the HCFA submitted by the provider. Per Rule 133.307 (g) (3) (D), the reimbursement data evidence submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" Out of the six EOBs submitted by the provider, one was not redacted and three had the address of the patient. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The insurance carrier submitted a methodology that meets Rule 133.304 (i). **No** reimbursement is recommended.
Totals		$959.00	$72.66				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 3rd day of February 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm